STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K091	A. BUILDING _____ B. WING _____	06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	1910 ST JOE CENTER ROAD, UNIT 41 FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was an initial Medicaid certification survey. This was a partial extended survey. Survey dates: June 26, 27, 2012 Facility #: IN012855 Census type: Skilled: 5 Home Health Aide Only: 5 Personal Care Only: 0 Total: 10 Sample: RR w/HV: 5 RR w/o HV: 10 Total: 10 Surveyor: Miriam Bennett, RN, BSN, PHNS QA: Linda Dubak, R.N. July 5, 2012	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation during home visit, policy review, and interview, the agency failed to ensure the Home Health Aide (HHA) followed infection	G 121		7/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 121	Continued From page 1 control policies for 1 of 2 home visit patients receiving HHA only services, with the potential to effect all the agency's patients who receive HHA only services. Findings include: 1. During home visit observation on 6/27/12 at 11:00 AM, employee D, a HHA, was observed giving patient #8 a bed bath. Employee D used the same pair of gloves throughout the bed bath without changing gloves. Also the same pair of gloves was worn to pick up soiled linens and then dress the patient. 2. The agency's policy titled "Infection Control/Exposure Control," not dated, was provided by employee A who indicated this was the agency's current policy. The policy states, "1. Patient infection control procedures shall include, but not be limited to: a. Wearing and changing gloves as necessary during the delivery of patient care. ... f. Examples requiring frequent hand washing by home care employees: After handling soiled or contaminated materials." 3. During interview on 6/27/12 at 12:50 PM, employee C indicated the HHA should have changed gloves when finished with bath and soiled linens.	G 121		